

# The Growth and Recovery Center

Eric Griffin-Shelley, Ph.D.

452 Germantown Pike

Lafayette Hill, PA 19444

and

6201 Hamilton Boulevard,

The George Building, Suite 107

Allentown, PA 18106

Mailing address: 4079 Oak Lane

Lafayette Hill, PA 19444-2612

**(610)828-4298**

Fax: 610-943-2322

the growthandrecoverycenter.com

Email: eric@drgriffin-shelley.com

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Okay to leave message? Yes \_\_\_ No \_\_\_

Work Phone: \_\_\_\_\_ Okay to leave message? Yes \_\_\_ No \_\_\_

Cell Phone: \_\_\_\_\_ Okay to leave message? Yes \_\_\_ No \_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (s): \_\_\_\_\_ Okay to leave message? Yes \_\_\_ No \_\_\_

Email: \_\_\_\_\_

## PARENT AND FAMILY HISTORY

What city did you live in while growing-up? \_\_\_\_\_

Who raised you? \_\_\_\_\_

How was the relationship between your parents? \_\_\_\_\_

If your parents were married, was there any history of separations or divorce? Yes No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

### Father

Name: \_\_\_\_\_ Current age: \_\_\_\_\_

If deceased, at what age did he die? \_\_\_\_\_ Cause: \_\_\_\_\_

Describe your father: \_\_\_\_\_

\_\_\_\_\_

Highest educational level attained: \_\_\_\_\_

Occupation: \_\_\_\_\_

Number of hours worked per week during your childhood: \_\_\_\_\_  
History of excessive alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of legal problems? Yes No If yes, explain: \_\_\_\_\_

History of emotional problems (mental illness)? Yes No If yes, explain: \_\_\_\_\_

Primary method of discipline: \_\_\_\_\_

**Mother**

Name: \_\_\_\_\_ Current age: \_\_\_\_\_  
If deceased, at what age did she die? \_\_\_\_\_ Cause: \_\_\_\_\_  
Describe your mother: \_\_\_\_\_

Highest educational level attained: \_\_\_\_\_

Occupation: \_\_\_\_\_

Number of hours worked per week during your childhood: \_\_\_\_\_

History of excessive alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of legal problems? Yes No If yes, explain: \_\_\_\_\_

History of emotional problems (mental illness)? Yes No If yes, explain: \_\_\_\_\_

Primary method of discipline: \_\_\_\_\_

Where do your parents currently reside: \_\_\_\_\_

Did either parent abuse or neglect you? Yes No If yes, explain: \_\_\_\_\_

If you could change anything about your parents or family, what would it be? \_\_\_\_\_

**Stepparent**

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Current age: \_\_\_\_\_ Year married to parent: \_\_\_\_\_

If deceased, at what age did he die? \_\_\_\_\_ Cause: \_\_\_\_\_

Describe stepparent: \_\_\_\_\_

Highest educational level attained: \_\_\_\_\_

Occupation: \_\_\_\_\_

Number of hours worked per week during your childhood: \_\_\_\_\_

History of excessive alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of legal problems? Yes No If yes, explain: \_\_\_\_\_

History of emotional problems (mental illness)? Yes No If yes, explain: \_\_\_\_\_

Primary method of discipline: \_\_\_\_\_

**Siblings**

#1 Name: \_\_\_\_\_ Sex: Male Female Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Married: Yes No Number of divorces: \_\_\_\_\_ Number of children: \_\_\_\_\_

Resides in what city/town? \_\_\_\_\_

History of mental illness? Yes No If yes, explain: \_\_\_\_\_

History of alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of criminal behavior? Yes No If yes, explain: \_\_\_\_\_

How often do you see this sibling: \_\_\_\_\_

How does this sibling get along with your children: \_\_\_\_\_

How close are you to this sibling: 1 2 3 4 5  
not at all extremely

#2 Name: \_\_\_\_\_ Sex: Male Female Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Married: Yes No Number of divorces: \_\_\_\_\_ Number of children: \_\_\_\_\_

Resides in what city/town? \_\_\_\_\_

History of mental illness? Yes No If yes, explain: \_\_\_\_\_

History of alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of criminal behavior? Yes No If yes, explain: \_\_\_\_\_

How often do you see this sibling: \_\_\_\_\_

How does this sibling get along with your children: \_\_\_\_\_

How close are you to this sibling: 1 2 3 4 5  
not at all extremely

#3 Name: \_\_\_\_\_ Sex: Male Female Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Educational Level: \_\_\_\_\_

Married: Yes No Number of divorces: \_\_\_\_\_ Number of children: \_\_\_\_\_

Resides in what city/town? \_\_\_\_\_

History of mental illness? Yes No If yes, explain: \_\_\_\_\_

History of alcohol or drug abuse? Yes No If yes, explain: \_\_\_\_\_

History of criminal behavior? Yes No If yes, explain: \_\_\_\_\_

How often do you see this sibling: \_\_\_\_\_

How does this sibling get along with your children: \_\_\_\_\_

How close are you to this sibling: 1 2 3 4 5  
not at all extremely

*If you have more than three siblings, please give additional information on the back of this page.*

**PERSONAL HISTORY**

Significant Events in Your Life (i.e., losses, moves, injuries, honors, championships, etc)

Ages birth to 5: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 6-10: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 11-15 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 16-20 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 21-30 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 31-40 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 41-50 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ages 51-Present  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*If you need more space, please give additional information on the back of this page.*

**Education**

Elementary School: \_\_\_\_\_ District: \_\_\_\_\_

Middle School: \_\_\_\_\_ District: \_\_\_\_\_

High School: \_\_\_\_\_ District: \_\_\_\_\_

Number of suspensions from school: \_\_\_\_\_

Did you graduate from high school? Yes No If yes, when? \_\_\_\_\_

Grade point average in high school \_\_\_\_\_

Sports or clubs you participated in school: \_\_\_\_\_

Did you receive any tutoring, counseling, or special education assistance during your schooling? Yes No If yes, explain: \_\_\_\_\_

Please list any **post-high school training**:

School: \_\_\_\_\_ Date \_\_\_\_\_ to \_\_\_\_\_

Type of Training or Major \_\_\_\_\_

Degree: \_\_\_\_\_ Grade Point Average: \_\_\_\_\_

School: \_\_\_\_\_ Date \_\_\_\_\_ to \_\_\_\_\_

Type of Training or Major \_\_\_\_\_

Degree: \_\_\_\_\_ Grade Point Average: \_\_\_\_\_

*If you need more space, please give additional information on the back of this page.*

**Armed Services Experience**

Were you in the armed services? Yes No If no, please go to next section.

Branch \_\_\_\_\_ Length of time served \_\_\_\_\_

Type of work \_\_\_\_\_

Highest rank achieved \_\_\_\_\_

Any awards/commendations received? Yes No Describe: \_\_\_\_\_

Any disciplinary action? Yes No If so, why: \_\_\_\_\_

Type of discharge: \_\_\_\_\_

Feelings/thoughts about time in service \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Employment**

Current employer: \_\_\_\_\_

Type of work: \_\_\_\_\_

Dates of Employment From: \_\_\_\_\_ To: \_\_\_\_\_

Work hours: Monday \_\_\_\_\_ to \_\_\_\_\_ Tuesday \_\_\_\_\_ to \_\_\_\_\_

Wednesday \_\_\_\_\_ to \_\_\_\_\_ Thursday \_\_\_\_\_ to \_\_\_\_\_

Friday \_\_\_\_\_ to \_\_\_\_\_ Saturday \_\_\_\_\_ to \_\_\_\_\_

Sunday \_\_\_\_\_ to \_\_\_\_\_

How often do you work weekends? \_\_\_\_\_

Do you work at home? Yes No How many hours? \_\_\_\_\_

On average, how many hours do you work per week? \_\_\_\_\_

Current salary \$ \_\_\_\_\_

Do you have medical insurance from your employer? Yes No

How would you describe your work record on this job? Poor Fair Good Very Good

Is this job stable? Yes No If no, explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any other employment? If so, explain: \_\_\_\_\_

\_\_\_\_\_

What age did you start working? \_\_\_\_\_

Have you had steady and consistent employment for the majority of your adult life? Yes

No If No, explain: \_\_\_\_\_

Have you ever been fired from a job? Yes No If No, explain: \_\_\_\_\_

\_\_\_\_\_

Do you find work satisfying and enjoyable? Yes No If No, explain: \_\_\_\_\_

\_\_\_\_\_

Are there any other concerns about your work/occupation? Yes No If No, explain: \_\_\_\_\_

\_\_\_\_\_

**Past Employment:**

Name of company: \_\_\_\_\_

Type of work: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Name of company: \_\_\_\_\_  
Type of work: \_\_\_\_\_  
Dates of Employment: From \_\_\_\_\_ To: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name of company: \_\_\_\_\_  
Type of work: \_\_\_\_\_  
Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

*If you need more space, please give additional information on the back of this page.*

**Financial Situation**

How is your financial situation at this time? (circle one)  
Bad Fair Good Very Good  
How much are you in debt, other than mortgage or car payments? \$ \_\_\_\_\_  
Have you ever filed for bankruptcy? Yes No If yes, explain: \_\_\_\_\_

At this time, are you able to pay bills and provide essential needs for your children?  
Yes No If no, explain: \_\_\_\_\_

Do you gamble? Yes No If yes, describe: \_\_\_\_\_

Do you have a problem with debting or over-spending or shopping? Yes No If yes, describe: \_\_\_\_\_

**Physical Health**

How would you describe your current physical health? (circle one)  
Poor Fair Good Very Good Excellent  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_  
Last physical exam: \_\_\_\_\_  
List any medical problems: \_\_\_\_\_

List any past surgeries: \_\_\_\_\_

Do you have any scars or tattoos? Yes No If yes, please explain: \_\_\_\_\_

Current medications: \_\_\_\_\_

Past medications: \_\_\_\_\_

Are you pregnant? Yes No Not Applicable If yes, when are you due? \_\_\_\_\_

Are you taking birth control? Yes No Not Applicable

Have you have a Miscarriage and/or Abortion? Yes No If yes, please explain:

### **Mental Health**

How would you describe your mental and emotional health at this time? (circle one)

Poor Fair Good Very Good Excellent

Have you ever had therapy or counseling for emotional or mental problems?

Yes No If yes, please identify the reasons, dates, and clinic/therapist,

Have you ever taken medication for emotional problems? Yes No If yes, which one(s): \_\_\_\_\_

Are you currently taking medication for emotional problems? Yes No If yes, which one(s): \_\_\_\_\_

Who prescribes your medication? \_\_\_\_\_ Family Practitioner \_\_\_\_\_ Psychiatrist

Your doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Have you ever been hospitalized because of emotional problems? Yes No

If yes, please identify the hospital, dates, and reason: \_\_\_\_\_

Current stressors in your life: \_\_\_\_\_

Do you have any history of self-inflicted injuries or cuts? Yes No If so, explain:

Do you have any history of suicide attempts? Yes No If yes, how many times, why, & when? \_\_\_\_\_

Any history of sexual abuse? Yes No If yes, describe: \_\_\_\_\_

Have you been exposed to severe trauma (interpersonal, accident, war, torture, battery,



medical, natural disaster, or other traumas)? If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Substance Abuse**

What type of alcohol beverages do you enjoy? \_\_\_\_\_

How often do you consume alcoholic beverages? \_\_\_\_\_

How much alcohol do you usually consume when drinking? \_\_\_\_\_

How many times have you been intoxicated (drunk) during the past year? \_\_\_\_\_

During the past five years? \_\_\_\_\_

Have you ever experienced black outs from consuming alcohol? Yes No If so, explain: \_\_\_\_\_

Has anyone ever expressed concern about your alcohol consumption? Yes No If so, who and why? \_\_\_\_\_

Have you ever received a DUI (driving under the influence) conviction? Yes No If so, explain: \_\_\_\_\_

What types of drugs have you used: (check those that apply)

\_\_\_\_ Marijuana \_\_\_\_ Cocaine \_\_\_\_ LSD \_\_\_\_ Heroin \_\_\_\_ Speed \_\_\_\_ Barbiturates

\_\_\_\_ Other: \_\_\_\_\_

If any of the above is checked, please describe the age you started using the drug and amount of usage: \_\_\_\_\_

Did you ever sell drugs? Yes No If yes, please explain: \_\_\_\_\_

Have you ever attended AA or received therapy for substance abuse? Yes No If so, explain: \_\_\_\_\_

Do you smoke tobacco? Yes No If so, how many packs of cigarettes do you consume per day? \_\_\_\_\_ If other tobacco products, please list: \_\_\_\_\_

Do you consume highly caffeinated drinks? Yes No If yes, which ones and how much? \_\_\_\_\_

**Legal or Criminal History**

Have you ever been detained or arrested? Yes No If so, explain: \_\_\_\_\_

Have you ever been charged with a crime? Yes No If so, explain: \_\_\_\_\_

Have you ever been convicted of a crime? Yes No If so, explain: \_\_\_\_\_

Were you ever in jail or prison? Yes No If so, explain: \_\_\_\_\_

Has your driver's license ever been suspended? Yes No If so, describe: \_\_\_\_\_

\_\_\_\_\_

If you have an attorney, your attorney's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Religious Beliefs**

Were you raised according to a certain religious faith? Yes No If so, explain: \_\_\_\_\_

What is your current religious affiliation? \_\_\_\_\_

Do you attend services on a regular basis? Yes No

Are religious issues an area of controversy in the raising of the children? Yes No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Interests**

Please describe your interests:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social Network**

How many close friends do you have? \_\_\_\_\_

How often do you spend time with friends? \_\_\_\_\_

Please describe people that you can rely on for assistance or help:

\_\_\_\_\_  
\_\_\_\_\_

*If you need more space, please give additional information on the back of this page.*

**Current Residence**

Describe your current residence: Circle one: apartment    condo    home

Square footage: \_\_\_\_\_ Number of bedrooms: \_\_\_\_\_

Number of blocks from school: \_\_\_\_\_

Number of children in immediate neighborhood: \_\_\_\_\_

How long have you lived at this residence? \_\_\_\_\_

How much are your monthly payments? \$ \_\_\_\_\_

What are the advantages of this residence? \_\_\_\_\_

What are the disadvantages of this residence? \_\_\_\_\_

Do you plan to remain in this residence? Yes No If no, explain: \_\_\_\_\_

**Relationship History**

At what age did you start dating? \_\_\_\_\_

How many different boyfriends/girlfriends did you have in high school? \_\_\_\_\_

How many long-term relationships (6 months or longer) have you had? \_\_\_\_\_

How many times have you been married? \_\_\_\_\_

Date of first marriage: \_\_\_\_\_

What originally attracted you to this person?

\_\_\_\_\_  
\_\_\_\_\_

What made you decide to marry this person?

\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following that were problems during the relationship:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> arguing        | <input type="checkbox"/> money misuse         | <input type="checkbox"/> job problems      |
| <input type="checkbox"/> drug abuse     | <input type="checkbox"/> alcohol abuse        | <input type="checkbox"/> sexual problems   |
| <input type="checkbox"/> sexual affairs | <input type="checkbox"/> child rearing issues | <input type="checkbox"/> domestic violence |
| <input type="checkbox"/> ill health     | <input type="checkbox"/> emotional distance   | <input type="checkbox"/> lack of love      |

Do you have children from this marriage? Yes No If so, please provide:

Name	Age	Date of Birth
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

What is the relationship like between your children's father and the children?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have divorced, what made you decide to terminate the relationship with this person?

\_\_\_\_\_  
\_\_\_\_\_

Who filed for divorce? \_\_\_\_\_ Date: \_\_\_\_\_

Is the divorce final? Yes No If yes, date: \_\_\_\_\_

What is the relationship like between your ex-spouse and the children now?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If applicable, date of second marriage: \_\_\_\_\_

What originally attracted you to this person?

\_\_\_\_\_  
\_\_\_\_\_

What made you decide to marry this person?

\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following that were problems during the relationship:

arguing     money misuse     job problems  
 drug abuse     alcohol abuse     sexual problems  
 sexual affairs     child rearing issues     domestic violence  
 ill health     emotional distance     lack of love

If you have divorced, what made you decide to terminate the relationship with this person?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have children from your second marriage? Yes No If so, please provide:

Name	Age	Date of Birth
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

What is the relationship like between your second spouse and the children? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have children from any other relationship? Yes No If so, please provide:

Name Age Date of Birth

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What is the relationship like between this person and the children? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have a divorce attorney, your attorney's name:

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

*I have provided true and accurate information on this form, as I attest by signing below.*

Signature \_\_\_\_\_ Date \_\_\_\_\_